The Interventive Relationship: Purposeful Practice and Transforming Adverse Experiences

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Abstract

This paper presents the theoretical underpinnings of a particular type of working alliance, the 'Interventive Relationship' (IR), based on case study evidence from Extern, a voluntary organisation in Northern Ireland working with children, adults and families presenting with experiences of adversity. Third sector organisations, such as Extern, play a crucial role, providing individual and group interventions with groups assessed at "risk". Such organisations operate in a context of austerity, where resource competitiveness and constraints place operational demands on programme delivery. Pressure for outcomes, evidence and accountability can have a negative impact on interactions founded on process and relational approaches.

This paper examines the validity and purpose of "*relationship based, and process led approaches*" and proposes a model for articulating change in multi-disciplinary practice with client groups where childhood and adulthood adversity are a significant theme. It articulates and expands on a distinction between the use of self in therapeutic counselling and in multi-disciplinary social and youth work settings. Using case study methodology, respondent perceptions about the process and depth of interaction between worker and service user were examined. The essential factors that contribute toward positive change, facilitate risk reduction and contribute to increased resilience are examined. The Interventive Relationship (IR) is presented as a five-stage sequential model, (initiation/foundation/preparation, developing/negotiation, synthesis/unity point, autonomy/independence and finally quantitative/qualitative outcomes. The essential ingredients and necessary conditions for transformative learning, or change process, through the model are illustrated and

presented diagrammatically.

Keywords: Interventive Relationship; Qualitative outcomes; elements; working alliance; resilience;

The gross national product does not allow for the health of our children…their education, or the joy of their play. It does not include the beauty of our poetry or the strength of our marriages; the intelligence of our public debate or the integrity of our public officials. It measures neither wit nor courage; neither our wisdom nor our teaching; neither our compassion nor our devotion to our country. It measures everything, in short, except that which makes life worthwhile.
Robert F. Kennedy, 1968

Introduction and Context

This article presents the theoretical development of a practice alliance, the 'Interventive Relationship' (IR), the underpinning basis of which is a relational approach. IR is articulated as consisting of a set of worker characteristics and core conditions that, if present can facilitate effective change process.
The nature of purposive relationship approaches is considered, and how conditions required for the formation of effective alliance are created. How such collaborative and co-created client/worker relationship contributes to the process of achieving successful qualitative outcomes is discussed. The IR was developed in the context of Extern, a third sector organisation providing services for young people, adults and families in Northern Ireland and the Republic of Ireland.

Relationship, Rapport and Alliance in Practice

Professional disciplines in the social sciences, such as youth work and social work, are predicated upon a helping relationship. Such relational approaches centre on the worker use of self, and the establishment of an alliance aimed toward education, well-being, promotion of health and personal and social development for service

users.

The practice and programmes founded upon relational approaches draw heavily upon counselling theory, therapeutic concepts and skills, including the use of self (Wosket, 2001) (Baldwin, 2013) and working alliance (Zetzel 1956, Bordin, 1976). A successfully established helping relationship or alliance creates a rapport, facilitates the establishment of contract and allows for the development of a collaborative engagement with the aim of enabling improved awareness, empowerment of self and transformative learning for clients. Due to its usefulness the working alliance has also become the foundation of individual and group based social and youth work interventions that are aimed toward formal and informal education and social or personal development. These *relationships based, and process led approaches* aim to support a process for change, for risk reduction, for improved resilience in clients and are the foundation for interventions in multi-disciplinary practice with adversity impacted young people.

In the UK and Northern Ireland, third sector organisations are commissioned to deliver services on behalf of state agencies and play an invaluable role, offering hands-on interventional activities with adversity impacted groups. However, these organisations exist within a funding context which places operational pressures on interactions between worker and clients and indeed, outcomes, evidence and accountability are fundamental to such organisations gaining funding. Articulating the characteristics, validity and purpose of "*relationship-based programmes*" to the satisfaction of funding bodies can be a difficult task. Of course, the achievement of outcomes can offer standardised measurements on certain criteria, a necessary method of accountability for commissioned and funded programmes. However, it can also be the case that such a focus can fail to consider, document or facilitate the importance of relationship development, the working alliance in process work and the contribution it makes toward change, a gap which this paper aims to address.

Relationship in Social Work

Mc Mullin (2017) considers relationship building as an intervention and the foundation to good practice in social work (2017). Across disciplines the rapport between worker and client is essential. For social and youth work agencies, pressure and demand prioritises interventions, assessment and service delivery resulting in limited time for relationship building. More than an intervention, building

relationship requires advanced macro and micro skills. A successful alignment between worker and service user is dependent on worker qualities, characteristics, level of self-awareness and the interest and capacity for developing the same. Most importantly relationship building requires capacity, space and time regardless of the context in which service delivery takes place.

Counselling and Helping Skills-The distinction

The effective use of helping skills in youth and social work programmes can improve emotional literacy, knowledge and social competence and improve resilience for those adversity impacted. Whilst helping skills and therapeutic counselling have in common the creation of an environment, in which the client seeks positive change and a more meaningful connectedness both intra- and inter-personally; what distinguishes the two is the purpose and depth of the engagement. There is a contractual distinction in the collaborative and multifaceted venture of counselling requiring expertise, knowledge and skills in its interventions and exploration toward improved understanding of the self and resolution of complex themes.

This distinction between therapeutic counselling, the use of counselling skills, and the concept of helping in social, education and youth work is an important one in clearly defining purpose, method, content and boundaries in social programmes offered by the disciplines. There is some debate in social sciences about the nature of relationship and its changing status in the face of economic challenges, yet research demonstrates that process and relationship, accessibility and timing, feedback and evaluation and offering a client centred flexible service are factors that contribute to the quality and success of therapeutic practice and programmes. Cognitive Behavioural Therapy, psychodynamic and humanistic counselling models were found to have similar outcome profiles for improvement and recovery in moderate severity clients across a number of studies. (Stiles et al 2006, 2008) (Mellor-Clark:2017).

Helping skills in community, social work and multi-disciplinary contexts primarily use an integrative training model based on the aforementioned therapeutic disciplines. Practitioners utilise theoretical knowledge and skills in practice

established with dominant characteristics of relational and interpersonal approaches. Informed by person centredness, practice endeavours aim to engage in primarily nurturing and supportive mode, with a basis of mutual trust.

Recent developments, austerity and funding constraints has generated debate about a change in approach resulting in a worker to client relationship that is more contractual and service oriented, with an emphasis on a transactional and economically driven basis for intervention (Ruch :2010) and subsequently this not only impacts the type of engagement, but also the quality of engagement.

Outcome Measurement and Outcome Management

In the current economic community and voluntary (C&V) sector organisations are increasingly experiencing reduced funding for programmes, placing operational pressures on process or relational based practice (Simmons and Griffiths 2009). The focus can change to an agenda that is funder led, with outcome based; time limited interventions that may jeopardise relational based practice between worker and client. Studies indicate that the engaging phase with clients and length and quality of therapist effect are the most significant factor for success and contribution to positive client change (Hansen, Lambert and Forman:2002). This paper distinguishes between outcome measurements considered a passive experience for service users' and outcome management which involves the service user in a collaborative experience during the contracted relational experience.

Relationship and Use of Self

Disciplines operating from a relational perspective have the use of self as a foundation, it is not simply the attendance and "showing up" of self but the purposeful, diligent application in a focused way. Purposefulness includes resolve, persistence and perseverance, important elements in creating conditions for client growth. Awareness of self includes capacity for emotional literacy, thoughts, senses and intuition, with thoughtful, focussed use of these aspects in deliberate and mindful manner in practice.

Lambert (2011) and Boswell (2013), argued that effective alliance offered an improved experience and greater degree of success for clients, however, as research demonstrates, describing subjective experiences of self, articulating concepts such a process of change and rapport is fraught with difficulty. Such concepts are dense,

they are complex concepts, often hard to measure and articulate.
Research studies demonstrate the intricacy and complication in capturing and describing the meaning of "alliance", how change process occurs and how relational boundary and purpose is defined in therapeutic and indeed helping professions. While there is a sizeable body of literature on the working alliance in therapeutic settings (see Florsheim, et al 2000, Hawley and Garlin 2008 and Karver et al 2005) A distinction is thus required between a therapeutic relationship founded on perceptions between therapist and client, and a working alliance which is a joining of the clients "reasonable self or ego and the worker's analysis self or ego for the purpose of the work" (Gelso and Carter 1994:297).

Exactly what is meant by practitioners when discussing the importance of the relationship in practice? The concept is commonly described as central, partly based on earlier research that found relationship to be more important than different models, techniques and theories in successful therapy. Factors described as relational include non-judgemental attitude, warmth, concern and empathy, trust and, as stated above, rapport. Lambert (1992) found the relationship to be responsible for 30% of successful outcome and the remainder comprised of skills, techniques, theory and additional therapeutic factors. Colin Feltham (2013) believes practitioners are generally describing good rapport when discussing a good relationship. As stated above, the ingredients of relational practice are subtle, difficult to articulate. Relationship comprises elements such as personality, intuition, social and cultural themes, in addition to factors such as humour (Brendtro, 2009), authenticity and congruence.
In addition, measurement of progress during therapy and programmes, using a range of outcome and clinical support tools, e.g. CORE OM that offer feedback to practitioners indicate an improved experience and greater degree of success for clients (Lambert:2011, Boswell:2013). Feedback and measurement can improve outcomes which can be used by practitioners (Kim de Jong:2012) however measurement of product, in and by itself must not become prioritised over the process with the client.
Describing relationship across helping settings can be equally confusing and unclear, with distinctions between informal and formal settings, nature of purpose,

reason for engagement and meaning making by practitioners. The centrality of self in practice aimed at reducing risk and improving resilience with young people considered as "adversity impacted" is a foundation to social and youth work practice. Variables including perspectives about relational use of self in practice, organisational factors that support or inhibit the formation of IR and workers understanding of theory are important considerations for effective practice**.**

Reclaiming Concepts: Risk and Resiliency- From deficit to strength

Historically, models in psychology were founded on the basis of natural sciences and physics, rather than life and health sciences. Freud described a focus of practice aimed at replacing neurotic misery with ordinary unhappiness and Seligman (1998) describes the focus of psychology as trying to cure mental illness. In his challenge to psychiatry, Seligman (1998), argues that practice became a victimology, where people were considered as passive, with external "reinforcements" either weakening or strengthening *"*responses". People were considered as subjects being controlled or influenced by conflicts from childhood. Viewing the human being as essentially passive, psychologists treated mental illness within a theoretical framework of repairing damage. This articulated the pathologizing of emotional and mental health, predicated on a medical model of personal weakness which ignored human potential.

Social and Youth Work

Drawing from psychology, practices across social and youth services were also traditionally deficit based in approach. They endeavoured to understand weakness and the problems and pathology associated with human behaviour. Assessment and interventions neglected human strengths, capacities and positive behaviours, thus a more balanced move from deficit approach toward assets was often lost. Seligman (2011) argues that whilst there were numerous developments in the understanding of emotional and psychological ill health the human was considered as passive, the theoretical framework was the repair of damaged "habits, damaged drives, damaged childhoods and damaged brains" (2011). Recent years have witnessed a shift

toward prevention, strength and resiliency-based approaches that emphasise protective factors and create the circumstances that moderate the effects of risk in the lives of clients.

Adversity experiences and Mental Health

Positive psychology is the science and applications associated with the study of psychological strengths and positive emotions. Resilience, as an inferential concept, is characterised as patterns of positive adaptation in the context of significant adversity or risk (Masten, Cutilli, Herbers and Reed: 2009). Relationship-based approaches, interventions and programmes in social and youth work are resiliency based aimed at positive change and improved competence in the lives of clients. The approaches amplify strength rather than focus on weakness, the focus is potential**,** fostering assets and achievements. (Rutter:1985) (Werner & Smith:1982). D'Imperio, Dubow and Ippolito (2000) in identifying protective factors, determined culture and the input of a caring adult as two of the most persistent factors contributing to positive coping for young people affected by adversity.

Adversity and Risk

Risk is any circumstance or sequence of factors that increases the possibility of an unfavourable outcome, increases vulnerability or leaves a person more liable to peril. Failure to thrive physically and emotionally, declining mental health and poor decision making can be a consequence of adverse experiences resulting in negative outcomes for some young people. The result can present in challenging or "pain-based behaviours" such as offending (Brendtro, 2006) and practitioners require capacity and skills in responding to such presentations.

Varied factors can contribute to increased risk and the subsequent presentation of problems and difficulties. Causes can be individual factors, such as poor bonding, negative attachment experience or low self-esteem, family risk factors include inconsistent parenting and unstable home life. Risk can be linked to, and exacerbated by, peer influence or experience, such as impulsivity and negative behaviours. Cultural, environmental and community risk factors include levels of

deprivation, low aspirations and educational attainment. Risk factors include a range of psychological, social, and indeed, genetic influences, brain and hormonal factors, all of which can affect and coalesce to increase possibility of subsequent problems.

Research demonstrates that mental health difficulties tend to present in childhood or adolescence (Bunting, Murphy, O'Neill & Ferry, 2011). According to Green, Mc Ginnity, Meltzer, Ford and Goodman in a study of the prevalence of mental health issues for children, 10% of boys and 5% of girls had a diagnosable mental health condition. Early intervention is an important predictor for success in treatment and a positive outcome (Bunting et al., 2011), research demonstrating that social programmes promoting well-being can have positive impact and alleviate, can reduce risk of deteriorating mental health (Pattison and Harris, 2006) and improve the emotional wellbeing of young people.

A study from the Royal College of Surgeons in Ireland (RCSI) showed one in five young Irish adults aged 19-24 and one in six young people aged 11-13 were experiencing mental health problems (2013). The findings of the 'The Mental Health Of Young People in Ireland' report prepared by the RCSI Psychiatric Epidemiology Research across the Lifespan (PERL) group also indicate that high numbers of young adults aged 19-24 are engaged in the misuse of alcohol and drugs with over 1 in 5 meeting criteria for a diagnosable substance use disorder over the course of their lives and 1 in 20 meeting criteria for an alcohol use disorder at the time of the study. In particular concern and considering increased risk factors is that 3 out of 4 young adults (75pc) met criteria for binge drinking and 1 in 5 (19pc) had thought about suicide.

In considering mental health issues and young people, Northern Ireland has significantly high prevalence rates (McConnell, 2016) with evidence that individuals are not actively seeking the help they need and, like their counterparts in the Republic of Ireland, experiencing significant delays in accessing services (Bunting et al.,2011). Socioeconomic factors, family disruption and political instability in Northern Ireland, and causes mentioned above, have contributed to a higher risk and prevalence of offending behaviour and antisocial activity in particular geographic locations with resulting social exclusion and family based

problems. Schubotz & Mc Mullan, (2010) found, in a sample of young people with diagnosed mental ill-health conditions, that for over 50%, the significant mental health problem was exacerbated by the financial status of the family. In addition, unemployment and poverty (socio-economic deprivation) has negative impact on family quality of life, mental health and access to services (Dashiff, Dimicco, Myers & Sheppard, 2009). The term hidden harm refers to the influential effects of parental or family problems and their effect on behaviour and emotions of their children (Dashiff et al., 2009). Evidence suggests that the overwhelmed parent, with their own difficulties, will delay help seeking for the psychosocial problems of their child. (Owens, Hoagwood, Horwitz, Leaf, Poduska, Kellam & Ialongo, 2002)

Organisation and practice

Extern as a multidisciplinary organisation can be considered as creating a third space, (David Cracknell, and Zeichner, Homi Bhaba, Aoki) that space between professionals that creates a shared language and new thinking in organisations. "Third Spaces", as Bhaba states are 'Sites' where practitioners can think and develop, individually and collectively, and where the process of change could be nurtured, drawing on but not constrained and dominated by, the influence of current practice or the requirements of policy to initiate 'solutions' to 'problems" (2009). The nineties witnessed the growth of research exploring organisational responses in an ever changing environment. (Senge: 2006, Squirrell: 2012) and at the present time organisations are required to be responsive and proactive, essential in the current changing context of austerity and competition for funding.

An organisational culture will determine the conditions that either support relational or outcome driven practice. Establishing a relevant contract requires persistence, and commitment in targeting and engaging high risk clients. It necessitates flexibility (attending to client process and pace) and must be evidence based in its practice. Multi-disciplinary approaches in organisations must develop a shared language, a collaboration of knowledge in developing practice and transformative learning programmes. Inevitably the organisation must balance organisational and funder demands and as stated above, the current austerity and funding context, clearly exerts pressure for time limited projects, clear project cut offs, deliverables and measurable outcomes. This creates a focus exclusively about outcomes;

neglects process and can have a significant negative impact on the quality of contact for the organisation and consequently its practice with clients. The need for organisations to be proactive and adaptable, whilst essential, requires clarity of vision and ethos to ensure the fundamental principles of client centeredness, relational based interventions and process engagement are not to be compromised.

Introducing the Interventive Relationship (IR)

"*Staff and young people share experiences and contact with the whole family is collaborative*" (Youth Worker)

The **Interventive Relationship** is defined as a "*focused creative relationship involving a range of skilled interventions aimed at supporting a process of change".* (Friel: 2010); IR is collaborative and a partnership with a mutual consensus aimed adversity impacted reduction and improved resilience.

The stages of IR

The IR model has five stages; foundation, negotiating, unity, autonomy, and outcomes. Central to the model is the worker and their awareness of purposeful and relational practice and the client-worker collaboration within the organisation and wider context. Each stage of the model is underpinned by key principles and the five stage approach offers a method of articulating purposeful relational practice, the model is transferable and can be replicated across a range of programmes and settings

Stage 1: Foundation

The first stage is foundation or 'preparation for change' with the focus aimed at understanding the context of the referral, its review, allocation and initial contact between worker and client which can take place in a diverse number of settings (family context, residential settings, office and community locations) and including group or individual activities. This initial stage is one of attending, establishing rapport and setting initial parameters of the working alliance. Confidence, experience, and capacity to create depth, authenticity, and openness are emphasised as critical qualities, with a need for flexibility and attention to evidence based practice as important factors.

Figure Two: Interventive Relationship (IR) Poster

Stage 2: Negotiating

"The collaboration between ourselves and young people is hard to articulate, we have a collaborative relationship with the young people individually, at residential, in groups, during activities and we praise them…like any child" (social worker)

The principles underpinning stage two are determination, a commitment to high frequency contact and persistent engagement by staff aimed at a depth of rapport, empathy, knowledge, and assessment of client issues and needs. The worker plays a core role in case managing and negotiation of the IR. This stage there is frequent renegotiation, contracting, review of interventions and clarifying and reviewing the purpose and objective of IR for the client.

The organisational context will facilitate or inhibit stage two negotiations and it is crucial at stage two that the agency has an appreciation of the importance of process in relationship development. In addition the client must be valued as an active participant in the process of voluntary engagement based on principles of a democratic and exploratory approach. Stage 2 is nurturing, affirming demonstrating persistence that staff will "not give up" with identified crucial factors for stage 2 of respect, validation, consistency and genuine interest. Trust is required (Lambert

1992), attending to the client's experience and presiding as an ally (Diamond et al 1999). Research confirms that an exploratory, democratic and less directive approach is more positively received (Church 1994) in practice with young people. *"It is caring, nurturing, listening, supporting, warmth, positive regard and real"* (youth worker).

The relationship begins to involve a collaborative effort that emphasises mutually agreed goals and tasks within the context of a strong affective bond. Of crucial importance is the defining ***purposeful practical, hands-on "activity-based interventions"*** (Friel:2011), such as swimming, daytrips etc. These interventions create depth and serve to scaffold the negotiation, rapport and trust between workers and clients. *"Through individual work and group work we facilitate a conversation. We have an ethos…it is facilitating, questioning, with boundaries, not reactive and it is open"* (Social worker)

Pain based attitudes and behaviour including poor self-worth, self-loathing and disrespect of self can present as reluctance and resistance to engage, a pushing against support and challenging interactions. Stage 2 of IR is critical and cannot be time limited, is often resource intense with intervention roles in negotiation aimed at progressing to the unity point at stage 3.

Stage 3: Unity Point

"We create an alliance. It is subtle but deliberate, the client asks, "Am I safe"? When they feel trust, change happens". (Counsellor). The unity point in IR is the moment when the client considers an alternative perspective on their views and place in the world, a transformation co-created by worker and client within the context of the alliance. The unity point enables old patterns to fall away and the transformative space to arise where the client can reflect on and apply new experience and knowledge in the affirmed, positive space created through IR. This is the space where practitioner and client can think and develop, and where the process of change is nurtured and supported. Important factors at this stage is the capacity for presence, advanced and accurate empathic attunement, consistency and ensuring the client feels heard and supported in their change process and uniquely is the focus on creating effective boundaries in tuning into the clients' experience. It

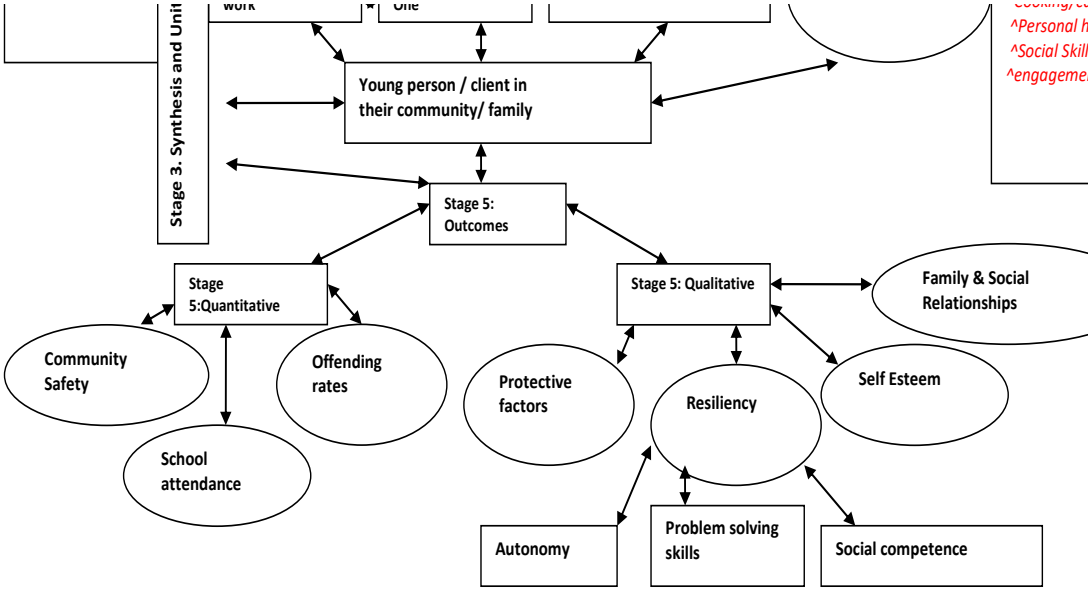
is critical to note that it is likely that clients may experience more than one unity point in their engagement with IR and progression is highly personal and often gradual, but at times can be immediate. As one worker stated, *"By aligning and sharing of self, we share their experience…change comes from that boundary"* (Youth Worker)

Stage 4: Autonomy

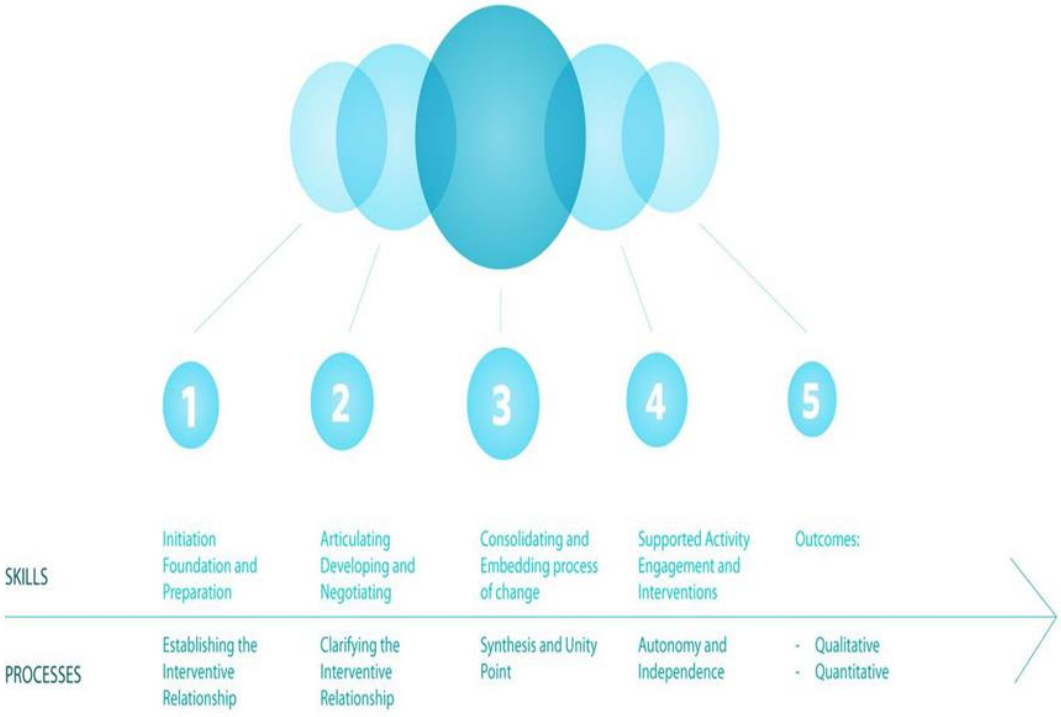
Stage 4 focuses on training, group and individual supported activity engagements, including family, in care and residential settings and involving activities such as: sports, leisure, social skills, outdoor skills, arts and crafts, cooking and personal care skills. Here the client becomes involved in more explicitly agreed objective and goal setting for the client's desired change. Brendtro (2006:28) argues that young people adversity impacted can be taught qualities such as responsibility, hope and courage. Assessment findings indicate that many young people who access the services lack that significant adult in their lives and resilience can only develop through IR. Interventions and engagements occur using a range of methods including; structured family work and therapy, informal family support, crisis interventions, group work, individual listening and social skills work in community settings. The process at stage four focuses on a review of training, attitudes and acquired skills. Benefits and improved autonomy with corresponding increase in confidence and self-worth is the aim of this stage and the IR.

Stage 5: Outcomes

The articulation of change can be difficult, as stated by a youth worker, *"It is difficult to measure what is not physically there".* Detecting and measuring qualitative relational practice in social and youth work disciplines presents a range of problems, however the identified the ingredients for developing the IR model, a purposeful interventive relationship impacts quantitative and qualitative measurement of outcomes as seen in figure one.



In creating the correct conditions through the IR at stages 1 – 4 the change process can be evidenced by measurable outcomes with possible comparison between quantitative outcome measurements (offending rates, community safety and school attendance) and improved resilience and critical qualitative outcomes including improved protective factors, improved family and social relationships, resilient achievements; problem solving skills, autonomy, social competence, improved self-worth and self-esteem. The Interventive relationship is presented in figure three offering a summary illustration of the IR model.



Conclusion

The Interventive Relationship (IR) has rapport, a working alliance and essential elements or characteristics at its foundation. It is a purposeful use of self by practitioners aimed facilitation of change and improved resilience for adversity impacted service users. Articulating the meaning of relationship in practices is complex, process is dense and the IR model is presented as a method of capturing and describing how change conditions are facilitated through strength-based relational approaches.

When working with young people there is a clear need to establish and maintain the relationship (Prever 2010) and it is evident that young people respond to and value qualities and behaviour, including humour and honesty, in relationships with adult helpers (Brendtro and Larson 2006), requiring organisations to provide suitable settings for the expression of these traits from their staff.

The interventive relationship is defined as a "*focused creative relationship involving*

a range of skilled interventions aimed at supporting a process of change". (Friel: 2010). This paper presents evidence that, with correct conditions, IR focuses on the client and creates a transformative experience which can support growth and change. The evaluation was small scale and the case study therefore cannot be considered exhaustive in gathering data from a range of sources. The authors recognise that replicating the findings and the validity of the evidence in the study is limited by the reliance on respondents self-reporting as a measure of activity. The aim of this evaluation was to focus on the Interventive relationship in order to clarify its nature and characteristics and how it moves a client forward. The 'unity point' or a connection that occurs between worker and client enables the process of change to take place. In addition evidence demonstrates that the experience of merger, reachable through attunement, and creating the correct conditions enable personal growth, development and improved resilience. Empathetic attunement occurs within the full context of the interventive relationship, and this unity point gives rise to the possibility of transformation and change for the client. To articulate this process requires a repositioning of emphasis into a more qualitative and subjective conversation about what takes place between staff member and client. A number of respondents describe the transformative process they witness in young people and adult clients within the organisation. Such transformative processes they found difficult to articulate to the satisfaction of generic recording requirements, but a number stated that what is experienced is a process which improves resiliency for young people and families, enables a process of change, outcomes to be met and risk reduced.

The evaluation was conducted in an organisation and there is acknowledgement of limitations to the study as it did not investigate the relationship between structural factors, external factors and how care is structured for the client. The transferability of the Interventive Relationship (IR) model across disciplines, including youth work and social work practice will inform engagement and development of practice with clients, particularly those requiring targeted intervention and considered difficult to engage. It is a useful endeavour to support the articulation of the process described, and in the current period of austerity and funding difficulties, it is essential to advocate the necessity of process and relationship in improving the lives of families, young people and communities

adversity impacted.

The evaluation established that respondents found the potential arising from purposeful use of the self, the nature and process of engagement, the relational approach with its subtlety, depth, intrinsic nature and ingredients difficult to articulate, demonstrate and describe to a satisfactory level. The evaluation findings capture the IR and process engagement supporting evidence of the transformative and Interventive Relationship. This paper articulates and visually presents the IR as a model highlighting the importance of relational based approaches in programmes aimed at improving outcomes and resilience in multi-disciplinary practice with adversity impacted young people.

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